Pitts&Associates
INCORPORATED

Adult Intake Form

Patient's Name:_____ **Date of Birth:**_____

Social Security Number:_____ ◯ **Male** ◯ **Female**

Street Address:_____

City: _____ **State:**_____ **Zip:**_____

Phone #1:_____ **Phone #2:**_____ **Phone #3:**_____
(#1 used for appt reminders)
Employed By: _____

Email Address: _____

Person Responsible for Payment:_____

Street Address:_____

City: _____ **State:**_____ **Zip:**_____

Phone #1:_____ **Phone #2:**_____ **Phone #3:**_____

Social Security Number:_____ **Employed By:** _____

PLEASE LET US KNOW <u>TODAY</u> if you are using your EAP for your initial visits. ◯ **Yes** ◯ **No**

If Yes, name & auth no. _____

PRIMARY_____ **SECONDARY**_____

Subscriber's Name: _____ **Subscriber's Name:** _____

Birth date of Subscriber: _____ **Birth date of Subscriber:**_____

Relation to patient: _____ **Relation to patient:** _____

Employer: _____ **Employer:** _____

Authorization #: _____ **Authorization #:** _____

I have contacted my insurance company concerning the Mental Health benefits, co-pays and deductions for the patient as they pertain to my provider.

Signature _____**Date:**_____
Patient or Responsible Party

NEXT PAGE please!

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I understand that, as a courtesy to me, Pitts & Associates files my insurance. I understand that Pitts & Associates is NOT responsible for keeping up with my insurance company's deductible, co-pays and/or the number of visits authorized by my Insurance. I also understand that my insurance company is NOT responsible for my bill, but that I am. If my insurance company does not pay in a timely manner, I will pay the bill in full.

Signature _____Date:_____

Patient or Responsible Party_____

I (We), the undersigned, hereby agree to pay all amounts and charges for services rendered by Pitts & Associates, Inc., no later than 30 days of the rendering of said services unless other specific arrangements are made. In the event of default of payment of said services, I (we) waive as to this debt all rights of exemptions under the constitution and laws of the State of Alabama, or of any other state, as to personal property, and agree to pay all costs of collection or securing or attempting to collect or secure said indebtedness, including a reasonable attorney's fee.
I ALSO UNDERSTAND THAT UNLESS A CANCELLATION OF AN APPOINTMENT IS MADE 24 HOURS IN ADVANCE OF SAID APPOINTMENT, I WILL BE SUBJECT TO CHARGE FOR THE TIME RESERVED

Signature _____Date:_____
Patient or Responsible Party

I authorize the release of any medical information necessary to process this claim and request payment to Pitts & Associates, Inc.

Signature _____Date:_____

Patient or Responsible Party_____

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Confidentiality agreement

You need to know that normally whatever you say or do during a counseling session will not be shared with anyone else without your written permission, with the following exceptions:

If you were referred by a specific agency, we may be required to furnish information to that agency.

If you were referred by a physician, it is customary to provide general progress reports to him or her. This will be done only if a consent form is signed by you.

I will keep brief written records of our sessions together. Under certain conditions, those records could be subpoenaed and I would then be obligated to surrender them. This would not be done without your knowledge.

If you report to me that you are currently the perpetrator or victim of child abuse, elder abuse or molestation, I am required to report this to authorities. If you have questions about this, please ask for clarification.

If you indicate that you intend to harm yourself or someone else, I must act to notify potential helpers or victims.

If you are a minor, I must keep your parents informed of your progress, if they ask. Details of our conversations do not have to be revealed.

If you are in couple's counseling and you tell me something in private that affects your relationship with your spouse, I reserve the right to bring it up in couple's counseling, since it is my belief that our work together cannot be effective if the members of the couple are keeping secrets from one another. I will ask for your permission first, if at all possible.

I hope and trust that our time together will be helpful to you. Counseling can bring positive growth yet painful awareness. Please feel free to discuss your reactions to your counseling with me at any point. It is my belief that counseling clients should be encouraged to make their own informed choices about their lives, including the decision to continue in counseling.

_____

Client Date

_____

Client Date

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Insurance

For your convenience, insurance claims are filed by our office staff following your visit. You may be responsible for a co-pay or deductible amount at the time of service.

If you plan to use insurance to help pay for services at Pitts & Associates, you will need to verify your coverage for mental health services before the first session. We have included a form at the end of this document to assist you in this process. Contact information for your insurance provider is usually located on the reverse side of your insurance card.

The following insurance companies are accepted by one or more of our clinicians. Please contact your insurance provider to verify your coverage.

Blue Cross Blue Shield of Alabama
Federal Blue Cross Blue Shield
Medicaid
American Behavioral
Behavioral Health Systems
Cigna
TriCare
Out of State Blue Cross Blue Shield
Medicare
Magellan
Value Options
United Behavioral Health
Aetna

Questions to ask your insurance company before your first visit with us:
(Bring this completed form with you to your first appointment)

What are my outpatient mental health benefits?_____
_____
_____

What is my yearly deductible? _____ Has it been met yet? _____

What is the renewal date for my benefits? _____

What is my co-pay once the deductible has been met? _____

Is authorization required? If so, what is my authorization number? _____

How many visits does this authorize? _____

What needs to be done to request additional visits? (Clinician send in treatment plan?)_____

Where? fax number or address _____

Where are insurance claims mailed? _____
_____
_____

PLEASE UNDERSTAND. Your insurance will NOT cover any charges for missed appointments or late cancellations (less than 24 hours advance notice).

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Therapist-Client Services Agreement

Welcome to Pitts & Associates. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of the first session.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

ABOUT PSYCHOTHERAPY
Individuals consult with Mental Health Professionals (MHPs) for a variety of reasons. We will make every effort to respect your individual needs and goals in treatment. The therapy process involves a working partnership between you and your MHP. Our work may include a variety of activities, and for optimum outcomes to occur, your active participation is essential. We will attempt to help you achieve your goals, but we cannot guarantee that the outcome will be what you now seek. In addition, change is often accompanied by feeling states that can be distressing. You may experience moments of frustration, anxiety, feelings of depression, self-doubt, and confusion. While we are trained, licensed and experienced MHPs, we cannot guarantee change nor can we promise that all problems will be resolved.

PROFESSIONAL FEES
The fee for an initial consultation with one of our psychologists (50 minutes) is $160.00. During the consultation, the client and therapist together will agree on the frequency of future visits, which will usually be 50 minutes ($140.00). Longer or shorter visits may be scheduled at times, and will be charged at the rate of $140.00 for 50 minute time segments.

Other fees:

1. Telephone consultations with you, or on your behalf, may be billed at a rate proportionate to the rate for therapy. Written communications to you or on your behalf will also be billed at a similar rate (e.g. letter preparation or email consultation).
2. The fee for returned checks is $30.00.
3. Any court appearance, or deposition, or the provision of documents for any attorney or for the court will be billed at a rate of $200 per hour, and will include preparation and travel time. Insurance does not cover these services. You may be asked to pay for time reserved in advance or pay a retainer, either of which is necessary before the court appearance or deposition can occur.
4. Psychological assessments/evaluations are charged at the rate of $170 per unit of time required for administration, scoring, interpretation, and report. Normally, one hour is charged for scoring, interpretation and report-writing. Certain reports that require substantially more time, detail and length (e.g. college reports that have to be written in ADA format) may require a 2-hour charge for scoring, interpretation and report-writing.

Payment is due at the time of service. We accept VISA, MasterCard, American Express, Discover, check and cash. If you have and are using Mental Health coverage, you MUST call to verify coverage, obtain pre-authorization (if required) and verify your co-pay amount and deductible remaining before the first visit, or you will be asked to pay full fee for the first visit. Please see the Insurance Worksheet, which follows in our downloadable forms packet for adults and children, which will guide you through calling your insurance carrier. Their phone number normally is on the back of your insurance card, as well as in your insurance benefits booklet. If you cannot reach your insurance company, ask your company supervisor or human resources/personnel representative.

CANCELLATION POLICY
As MHPs, we work as service providers. Therefore, our only commodity is our time (and expertise). A scheduled appointment is like a contract: the client has hired us to provide our undivided attention during a specified period of time. When someone fails to appear for a scheduled appointment, we are not able to fill in that time with another client. When appointments are cancelled less than 24 hours before the appointment, we likewise may not be able to fill the time.

If you give us 24 hours' notice of your intention not to use one of your appointments, we will not charge you for the time. If you fail to provide a 24-hour notice, you will be charged for the scheduled time. We cannot bill your insurance company for a missed appointment.

CONTACTING US
Our office hours are 8:00 am. to 5:00 p.m., Monday through Friday. We only have one telephone receptionist, thus you may at times have to leave a message. However, messages are checked often and calls returned promptly. Late afternoon messages left will be answered the morning of the next business day. Please do not ever leave an urgent message on voicemail. For emergencies during office hours, our voicemail message provides a number to call our answering service.

After hours, call the office number, 205-870-3520, to get the answering service number if you are experiencing an emergency. Please do NOT call the answering service regarding appointments. You may leave a non-urgent message that will be answered first thing on the next business day.

LIMITS ON CONFIDENTIALITY
The law protects the privacy of all communications between a patient and a MHP. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we avoid revealing the identity of our patient. Nonetheless, the other professionals are still legally bound to keep the information confidential. Unless you object, we may not tell you about these consultations, unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice.

If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

If the Alabama Board of Examiners in Psychology is requesting the information for an investigation of our practice, we are required to provide it for them.

If a patient files a complaint or lawsuit against one of us, we may disclose relevant information regarding that patient in order to defend ourselves.

If a patient files a worker's compensation claim, we may disclose information relevant to that claim to the patient's employer or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

If we know or suspect that a child under the age of 18 has been abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources (DHR). Once such a report is filed, we may be required to provide additional information.

If we know or suspect that ah elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that we file a report with the appropriate governmental agency, usually DHR. Once such a report is filed, we may be required to provide additional information.

If we believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s), we may disclose that information, but only to those reasonably able to prevent or lessen the threat.

If one of these situations arises, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, test results, and any reports that have been sent to anyone, including reports to your insurance carrier, If you provide us with an

appropriate written request, you have the right to examine and/or receive a copy of your records, except in unusual circumstances that involve danger to you or others. In those situations, you have a right to have your record sent to another mental health provider. In most situations, we are allowed to charge a copying fee of $1.00 (one dollar) per page (and certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, we may also keep a set of Psychotherapy Notes. These notes are for our own use, and are designed to assist us in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless we determine that such disclosure would be reasonably likely to be detrimental to your health.
Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

PATIENT RIGHTS
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We will be happy to discuss any of these rights with you.

MINORS & PARENTS
For therapy with children under the age of 14, it is our policy to request an agreement in which parents (or guardians) consent to give up access to the child's records. If a diagnostic evaluation or assessment is requested, we will discuss findings, results, and treatment plans with you. Most of the minors we see are brought voluntarily by their parents and come with parental knowledge. In such circumstances, parents are often understandably curious about the treatment of their children, It is our position, however, that young people need to develop trust in their therapist and need some degree of security and privacy. Therefore, we specifically request that you limit your inquiry about the details of their therapy. We need you to know that we will, indeed, bring to your attention matters that we believe are important for you to know, and we request that you trust our judgment about this important issue. We also hope that you will refrain from asking your child what has transpired in therapy or diagnostic sessions.

If your child is 14 or over, we cannot discuss anything about evaluation or treatment with you without the written Authorization from your child.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim.

INSURANCE REIMBURSEMENT
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will file your insurance claim and provide whatever assistance we can in helping you receive the benefits to which you are entitled: however, you (not your insurance company) are responsible for full payment of our fees. As stated earlier, you must call your insurance company to verify coverage and obtain pre-authorization (if required) before the first visit, or you will be asked to pay full fee for the first visit. Please see the "Professional Fees" section above for more information.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. At this point, the client will be required to pay full fee out of pocket, unless the MHP and client discuss a reduced fee in advance of the first non-covered session.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, and the accompanying Authorization, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE

Printed name of Patient _____

_____

Signature of Patient (Parent or legal guardian, if child is under age 14) Date signed

Revised 10/12

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Please turn this page in with your Intake Forms. Thank you.